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I. INTRODUCTION

A. Purpose

The purpose of this Request for Applications (RFA) is to fund at least one tobacco control project in each of the following priority populations: 1) African American; 2) American Indian/Alaskan Native; 3) Asian and Pacific Islander; 4) Hispanic/Latino; 5) Lesbian, Gay, Bisexual, and Transgender (LGBT); 6) Low Socio-Economic Status; 7) Blue and/or Pink Collar Workers; 8) Military; and 9) Rural Residents. Successful applicants must meet the scoring criteria and must demonstrate tobacco control needs among one or more of these priority populations. Applicants may address more than one population; however, one population must be designated as primary. Applicants may propose projects that will address the targeted populations' needs at the local, tribal, regional, or state level.

Successful applicants must be able to take culture, language, geographic, and socio-economic characteristics of the targeted populations into consideration in order to design and implement appropriate intervention and evaluation activities. Successful applicants must also have demonstrated experience with community norm change health education strategies, local program evaluation, administrative management of government funds, and the ability to partially equip proposed staff with computer and office equipment.

For the purpose of this RFA, applicants are expected to utilize the definitions of priority populations provided in this section or in referenced documents. The first six priority populations listed above are discussed and defined in the *Communities of Excellence in Tobacco Control, Module 3: Priority Populations Speak about Tobacco Control*, which is available at www.dhs.ca.gov/tobacco/documents/pubs/CX2006-Module3.pdf. For the remaining three priority populations (7, 8, and 9) please refer to the following definitions:

- The **Blue and/or Pink Collar Worker** priority population includes members of the working class. Blue collar workers perform manual labor and earn an hourly wage. Blue collar work may be skilled or unskilled, and may involve factory work, building and construction trades, mechanical work, maintenance, etc. Pink collar work involves jobs traditionally held by women that typically provide lower wages. Pink collar workers include: clerical workers, maids, nursing aides, waitresses, and food service workers. Studies have demonstrated that blue and pink collar workers have disproportionately high rates of smoking.

- The **Military** priority population is meant to only include members of the Army, Navy, and Marine Corps with a focus on enlisted personnel. These three branches of the military are targeted because a study conducted by the California Department of Health Services, Tobacco Control Section (CDHS/TCS), found that California enlisted members of these branches have significantly higher

smoking rates than the general California population.[1] Applicants addressing the military must demonstrate access to the population.

- The **Rural Resident** priority population includes individuals who reside in areas of the state that are defined as rural by the United States (U.S.) Census Bureau. Rates of tobacco use among rural residents are higher than rates for the general California population. The U.S. Census Bureau defines an area as rural if it does **not** meet the following definition for an urban area: "An urban area generally consists of a large central place and adjacent densely settled census blocks that together have a total population of at least 2,500 for urban clusters, or at least 50,000 for urbanized areas."[2] Applicants addressing rural residents need to demonstrate that the population to be reached resides in a rural area.

Funding for this RFA is made available pursuant to Health and Safety (H&S) Code Section 104385, which requires CDHS/TCS to award grants for projects directed at the prevention of tobacco-related diseases. Preference will be given to community-based organizations that have demonstrated effectiveness and a capacity to provide tobacco control interventions and serve populations in areas with substantial unmet needs.

This RFA will **not** fund efforts which address or include the following areas or activities: 1) a sole focus on provision of tobacco cessation services; 2) social sources of tobacco (i.e., friends or family); 3) tobacco retail licensing and efforts to reduce tobacco sales to minors in areas where local lead agencies (LLAs) are addressing these issues; 4) voluntary policy approaches to reduce retail tobacco advertising inside or outside the business; 5) smoke-free pledges to reduce exposure to secondhand smoke (SHS) in homes and vehicles; 6) planning objectives; and 7) sponsorship inoculation policies (i.e., policies for venues that are unlikely to be offered or accept tobacco funds).

B. Background on Proposition 99 Funding

In November 1988, California voters approved the passage of the Tobacco Tax and Health Protection Act of 1988, also known as Proposition (Prop) 99. This referendum increased the state cigarette tax by 25 cents per pack and added an equivalent amount on other tobacco products. The new revenues were earmarked for programs to reduce smoking, to provide health care services to indigents, to support tobacco-related research, and to fund resource programs for the environment. The money is deposited by using the following formula: 20 percent is deposited in the Health Education Account (HEA); 35 percent in the Hospital Services Account; 10 percent in the Physician Services Account; 5 percent in the Research Account; 5 percent in the Public Resources Account; and 25 percent in the Unallocated Account (Revenue and Taxation Code Section 30124).

[1] Crawford, R., C. Olsen, B. Thompson, and G. Barbour. *California Active Duty Tobacco Use Survey-2004*. Sacramento, CA: CDHS, 2005.
[2] U.S. Census Bureau, www.census.gov.

HEA funds both community and school-based health education programs to prevent and reduce tobacco use and is jointly administered by CDHS/TCS and the California Department of Education (CDE). Currently, CDHS/TCS receives approximately two-thirds of the funding and CDE receives approximately one-third of the funding available in HEA. CDHS/TCS is responsible for supporting a statewide tobacco control program, one of the largest public health interventions of its kind ever initiated, nationally or internationally. CDHS/TCS provides funding for 61 LLAs, competitively selected community-based organizations, a statewide media campaign, and an extensive evaluation of the entire California Tobacco Control Program (CTCP). CDE administers school-based funding to grades 4-8 based on an allocation method and to high schools through a competitive grant program.

The enabling legislation for Prop 99 includes Assembly Bill (AB) 75 (Chapter 1331, Statutes of 1989), AB 99 (Chapter 278, Statutes of 1991), AB 816 (Chapter 195, Statutes of 1994), AB 3487 (Chapter 199, Statutes of 1996), Senate Bill (SB) 99 (Chapter 1170, Statutes of 1991), SB 960 (Chapter 1328, Statutes of 1989), SB 493 (Chapter 194, Statutes of 1995); the annual State Budget; H&S Code, Sections 104350-104480, 104500-104545; and the Revenue and Taxation Code, Sections 30121-30130. These statutes and legislative language provide authority for programs administered by CDHS/TCS to:

- Conduct health education interventions and behavior change programs at the state level, in the community, and in other non-school settings.
- Apply the most current research and findings.
- Give priority to programs that demonstrate an understanding of the role community norm change has in influencing behavioral change regarding tobacco use.

Based on the current picture of tobacco use in California, CDHS/TCS intends to maintain focus on its four priority areas of: 1) reducing exposure to SHS and increasing the number of smoke-free public spaces where the population lives, works, and plays; 2) reducing the availability of tobacco products; 3) countering pro-tobacco influences in the community; and 4) providing cessation services. These priorities address key factors related to adult and/or youth tobacco use and are broad enough to encompass nearly all tobacco control activities. For more information on the CTCP, see Appendix A.

C. California Tobacco Control Program Progress and Challenges

The CTCP has been enormously successful. Adult smoking prevalence declined from 21.1 percent in 1989 to 14.0 percent in 2005, which reflects a 33.6 percent overall decline. Tobacco consumption has declined by 57.5 percent in California from fiscal year (FY), 1989-1990 to FY 2004-2005 while in the rest of the United States it has only declined 24.0 percent. Youth smoking prevalence has also declined dramatically in California, although in the most recent year, smoking

prevalence rose from 13.2 percent in 2004 to 15.4 percent in 2006. Nevertheless, California youth have a significantly lower smoking prevalence compared to the rest of the United States, and California had the second lowest youth smoking prevalence in the nation in 2004. These declines in smoking and consumption have translated into real health gains for Californians. Accelerated reductions have been documented in California for both heart disease deaths and lung cancer incidence rates. From 1988-2002, lung and bronchus cancer rates in California declined at almost four times the rate of decline in the rest of the United States.

Despite the tremendous accomplishments of the CTCP, there are still approximately 3.8 million adult and 200,000 youth smokers in California. In fact, the number of smokers in California exceeds the entire population of the state of Oregon. The burden of smoking is not equally shared across populations and communities in California. Low income, African American men and women, white men, Korean men, enlisted military personnel, LGBT, young adults, rural populations, and other populations experience tobacco use rates much higher than the general population.

For additional information on specific populations and communities that are impacted in unique ways by tobacco use, please refer to the following documents available at www.dhs.ca.gov/tobacco/html/publications.htm#0evaluationreports:

- *California Asian Indian Tobacco Use Survey – 2004*
- *California Active Duty Tobacco Use Survey – 2004*
- *California Chinese American Tobacco Use Survey – 2004*
- *California Korean American Tobacco Use Survey – 2004*
- *California Lesbians, Gays, Bisexuals and Transgender Tobacco Use Survey - 2004*
- *California Tobacco Control Update 2006: The Social Norm Change Approach*
- *Communities of Excellence in Tobacco Control, Module 3: Priority Populations Speak about Tobacco Control*

D. The California Tobacco Control Program Priorities

The CTCP's aim is to change the broad social norms around the use of tobacco by "indirectly influencing current and potential future tobacco users by creating a social milieu and legal climate in which tobacco becomes less desirable, less acceptable, and less accessible."[3] The social norm change model is based on the concepts that "the thoughts, values, morals, and actions of individuals are tempered by their

[3] A Model for Change: The California Experience in Tobacco Control, California Department of Health Services, Tobacco Control Section. Sacramento, CA: CDHS/TCS, 1998.

community" and "durable social norm change occurs through shifts in the social environment of local communities, at the grass roots level."

Under this social norm change paradigm, the CTCP focuses its tobacco control activities on these priority areas:

1. Countering pro-tobacco influences in the community: working to curb tobacco product retail advertisements (ads) and marketing practices, tobacco industry sponsorship, and the depiction of tobacco products in the entertainment industry.
2. Reducing exposure to SHS: initiatives that employ a policy and advocacy approach to restricting smoking in public and private places (emerging areas include policies associated with Indian casinos, multi-unit housing, and outdoor venues).
3. Reducing tobacco availability: supporting enforcement of the existing law that prohibits selling tobacco to minors, elimination of free tobacco product sampling, licensing of tobacco retailers, and establishment of tobacco-free pharmacies.
4. Promote cessation services: as a complement to the social norm change paradigm, the CTCP supports operation of the California Smokers' Helpline, as well as provides support for community-based cessation programs.

E. Communities of Excellence Indicator and Asset Priorities for Funding

Since 2002, CDHS/TCS has focused tobacco control needs assessment, planning, and implementation activities around a series of community indicators and assets called Communities of Excellence (CX) in Tobacco Control. Community indicators represent environmental or community level measures. They reflect intermediate programmatic goal areas around which to focus community-level tobacco control activities. Community assets represent factors that promote and sustain tobacco control efforts in the community by facilitating tobacco control work. Assets include such things as the level of funding available for tobacco control work and the extent of community activism among youth and adults to promote tobacco control policies.

There are over 90 CX indicators and assets. Applicants under this RFA must select from the indicators and assets listed below, which have been identified as being of particular relevance to specific priority populations. **CDHS/TCS will give funding preference to projects that address indicators and assets that are listed as "highly relevant."** However, applicants may also include objectives targeting "relevant" indictors and assets.

1. Counter Pro-Tobacco Influences

a. Highly Relevant

1.1.6 Number and type of tobacco company sponsorship at public and private events including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.

-or-

Proportion of entertainment and sporting venues with a voluntary policy that regulates tobacco company sponsorship including county fairs, rodeo, motor sports, other sporting events, parades, concerts, museums, dances, festivals, business, etc.

-or-

Proportion of communities with a policy that regulates tobacco company sponsorship at entertainment and sporting venues such as fairgrounds, concerts, museums, and events such as dance, business, festivals, etc.

1.1.11 Number and type of tobacco use, tobacco advertising, and SHS depiction by the entertainment industry (e.g., movies, music videos, TV, music, etc.)

-or-

The extent that elected officials, parent organizations, health groups, and others adopt resolutions and voluntary policies that promote a socially responsible depiction of tobacco use, tobacco advertising, and SHS by the entertainment industry (e.g., movies, music videos, TV, music, etc.)

b. **Relevant**

1.1.1 Number and type of in-store tobacco advertising and promotions

-or-

Proportion of businesses with voluntary policies that regulate the extent and type of in-store tobacco ads and promotions

1.1.2 Number and type of tobacco advertising and promotions outside of stores

-or-

Proportion of businesses with a voluntary policy that regulates the extent and type of tobacco advertising and promotions outside of stores

1.1.3 Number and type of tobacco ads in print media such as magazines and news papers

-or-

Proportion of print media organizations (e.g., magazines and newspapers) with a voluntary policy that regulates tobacco advertising

1.1.7 Number and type of tobacco company sponsorship and advertising at bars and clubs

-or-

Proportion of bars and clubs with a voluntary policy prohibiting tobacco company sponsorship and advertising

1.1.8 Number and type of tobacco company sponsorship and advertising at college-related events

-or-

Proportion of colleges with a policy that regulates tobacco company sponsorship and advertising

1.1.9 Amount of tobacco company contributions to institutions and groups such as education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, and social service institutions

-or-

Proportion of groups and institutions such as education, research, public health, women's, cultural, entertainment, fraternity/sorority groups, and social service institutions that have a voluntary policy prohibiting tobacco company contributions

1.1.10 Amount of tobacco industry contributions to support political campaigns of elected officials or political caucuses

-or-

Proportion of elected officials or political caucuses that have signed a pledge not to accept tobacco company contributions

1.2.1 Number and type of public (e.g., county and city government) and private institutions (e.g., unions, private universities) divested from tobacco stock

1.4.1 The amount of tobacco-related litter at public places including parks, playgrounds, beaches, etc.

-or-

Proportion of communities with a policy that prohibits tobacco litter in public places including parks, playgrounds, beaches, etc.

2. **Reduce Exposure to Secondhand Smoke**

a. **Highly Relevant**

2.2.6 Proportion of outdoor restaurant and bar businesses with a voluntary policy that designates outdoor dining and bar areas as smoke-free, including use of cigarettes, cigars, and hookahs

-or-

Proportion of communities with a policy that designates outdoor dining and bar areas as smoke-free, including use of cigarettes, cigars, and hookahs

2.2.7 Proportion of non-dining outdoor worksites (e.g. construction sites, lumber mills, forests) with a voluntary policy designating the worksite as smoke-free

-or-

Proportion of communities with a policy that designates non-dining outdoor worksites (e.g., construction sites, lumber mills, forests) as smoke-free

2.2.13 Proportion of multi-unit housing owners and/or operators with a voluntary policy that restricts smoking in individual units (including balconies and patios)

-or-

Proportion of communities with a policy that restricts smoking in the individual units of multi-unit housing (including balconies and patios), and/or resolutions encouraging owners, managers, or developers of multi-unit housing to adopt policies creating smoke-free individual units.

2.2.16 Proportion of outdoor recreational facilities, areas, and venues with a voluntary policy that regulates smoking in places such as amusement parks, beaches, fairgrounds, parks, parades, piers, playgrounds, sport stadiums, tot lots, and zoos

-or-

Proportion of communities with a policy that regulates smoking at outdoor recreational facilities, areas, and venues in places such as amusement parks, beaches, fairgrounds, parks, parades, piers, playgrounds, sport stadiums, tot lots, and zoos

2.2.25 Proportion of businesses with a voluntary policy that designates American Indian **casino/leisure complexes** as smoke-free to a level that is consistent with protection provided to other California workers under California Labor Code 6404.5

or

Proportion of American Indian tribes with a policy that designates **casino/leisure complexes** as smoke-free to a level that is consistent with protection provided to other California workers under California Labor Code 6404.5

b. **Relevant**

2.1.1 Number of compliance checks conducted by enforcement agencies for violations of indoor smoke-free worksite policies, **excluding bars and gaming** policies

-or-

Number of warnings, citations, and fines issued for violations of indoor smoke-free worksite policies, **excluding bars and gaming** policies

-or-

Proportion of worksites in compliance with indoor smoke-free worksite policies **excluding bars and gaming** policies

2.1.2 Number of compliance checks conducted by tribal enforcement agencies for violations with American Indian tribal indoor smoke-free worksite policies, **excluding gaming/leisure complexes** policies

-or-

Number of warnings, citations, and fines issued by tribal enforcement agencies for violations of indoor smoke-free worksite policies, **excluding gaming/leisure complexes** policies

-or-

Proportion of worksites in compliance with indoor smoke-free American Indian worksite policies, **excluding gaming/leisure complexes** policies

2.1.3 Number of compliance checks conducted by enforcement agencies for violations of indoor smoke-free bar and gaming worksite policies

-or-

Number of warnings, citations, and fines issued for violations of indoor smoke-free bar and gaming worksite policies

-or-

Proportion of worksites in compliance with indoor smoke-free bar and gaming worksite policies

2.1.4 Number of compliance checks conducted by American Indian enforcement agencies for violations of American Indian tribal indoor smoke-free **gaming/leisure complex** worksite policies

-or-

Number of warnings, citations, and fines issued by American Indian enforcement agencies for violations of American Indian tribal indoor smoke-free **gaming/leisure complex** worksite policies

-or-

Proportion of worksites in compliance with American Indian tribal indoor smoke-free **gaming/leisure complex** worksite policies

2.2.1 Proportion of homes with a smoker in the household who report their home is smoke-free

-or-

Proportion of families with a policy that does not permit smoking in the home

2.2.2 Proportion of families with a smoker who report their personal vehicles are smoke-free

-or-

The proportion of families with a policy that does not permit smoking in their personal vehicles

2.2.3 Proportion of businesses on American Indian lands with a voluntary smoke-free workplace policy, **excluding casino/leisure complexes**, that is consistent with protection provided to other California workers under California Labor Code 6404.5

-or-

Proportion of American Indian tribes with a smoke-free worksite policy, **excluding casino/leisure complexes**, that is consistent with protection provided to other California workers under California Labor Code 6404.5

2.2.4 Proportion of communities with a policy that regulates indoor worksite smoking in those areas that are exempted by the state smoke-free workplace law, such as owner operated bars and tobacco shops **(excluding hotels)**

2.2.9 Proportion of outdoor public areas, not primarily intended for recreational use, with a voluntary policy that regulates smoking, such as walkways, streets, plazas, college campuses, shopping centers, transit stops, farmers markets, and swap meets

-or-

Proportion of communities with a policy regulating smoking at outdoor public areas that are not primarily intended for recreational use, such as walkways, streets, plazas, school college campuses, shopping centers, transit stops, farmers markets, and swap meets

2.2.10 Proportion of health care facilities, drug and rehab facilities, and residential care facilities for the elderly, developmentally disabled, or mentally disabled with a voluntary policy that prohibits smoking by employees, residents, and visitors on the premises

2.2.11 Proportion of multi-unit housing complexes with a voluntary policy that designates common outdoor areas as smoke-free, such as playground, swimming pool area, and entrances

-or-

Proportion of communities with a policy that designates outdoor common areas of multi-unit housing complexes as smoke-free, such as playground, swimming pool area, and entrances, and/or resolutions encouraging owners, managers, or developers of multi-unit housing to adopt policies creating smoke-free outdoor common areas

2.2.12 Proportion of multi-unit housing complexes with a voluntary policy designating indoor common areas as smoke-free, such as laundry room, hallways, stairways, and lobby area

-or-

Proportion of communities with a multi-unit housing policy that prohibits smoking in indoor common areas such as laundry room, hallways, stairways, and lobby areas, and/or resolutions encouraging owners, managers, or developers of multi-unit housing to adopt policies creating smoke-free indoor common areas

2.2.18 Proportion of foster care homes or agencies with a voluntary policy that regulates smoking

-or-

Proportion of communities with a policy or resolution that regulates smoking within foster care homes

2.2.19 Proportion of businesses and venues with a voluntary policy that regulates smoking in outdoor waiting lines (e.g., movie theaters, sporting events, entertainment events, food service, restrooms, Automated Teller Machines [ATMs], etc.)

-or-

Proportion of communities with a policy that regulates smoking in outdoor waiting lines (e.g., movie theaters, sporting events, entertainment events, food service, restrooms, ATMs, etc.)

2.2.20 Proportion of faith community organizations (e.g., churches, synagogues, mosques, and temples) with a policy that regulates smoking on their grounds and at events

3. **Reduce Availability of Tobacco**

a. **Highly Relevant**

3.2.4 Proportion of venues with voluntary policy that prohibits the distribution of free or low-cost tobacco products, coupons, coupon offers, or rebate offers for tobacco products

-or-

Proportion of communities or events with a policy that prohibits the distribution of free or low-cost tobacco products, coupons, coupon offers, or rebate offers for tobacco products

3.2.7 Proportion of independent and chain pharmacy stores with a voluntary policy to NOT sell tobacco products

-or-

Proportion of communities with a policy that prohibits the sale of tobacco products by independent and chain pharmacy stores

b. **Relevant**

3.2.2 Proportion of communities with a zoning policy that regulates the number, location, and density of tobacco retail outlets (e.g., conditional use permits)

3.2.6 Proportion of communities with a policy that prohibits tobacco sales via mobile vendors

3.2.8 Proportion of communities with a policy or resolution that regulates the sale of tobacco and nicotine containing products that are not intended to facilitate tobacco cessation, but rather are promoted as having lower health risks in comparison to traditional tobacco products or that are promoted for use in lieu of smoking where smoking is not permitted

4. **Promote Tobacco Cessation Services**

a. **Highly Relevant**

4.1.1 Number of culturally and linguistically appropriate behavior modification-based tobacco cessation services that are available and well utilized in the community

b. **Relevant**

4.2.3 Extent of policies that restrict or prohibit use of alternative tobacco products (e.g., smokeless tobacco) at the worksite

4.2.4 Number of alcohol and drug treatment, mental health treatment, migrant clinics, and other health or social service agencies that have implemented the U.S. Public Health Service clinical practice guidelines *Treating Tobacco Use and Dependence*

5. **Assets**

Note: CDHS/TCS will not fund any project that exclusively focuses on assets. However, projects that propose a mix of activities (e.g., assets with non-cessation indicators) will be considered.

a. **Highly Relevant**

Asset 2.3 Amount of support by local key opinion leaders for tobacco-related community norm change strategies

Asset 2.4 Amount of community activism among youth to support tobacco control efforts

Asset 2.5 Amount of community activism among adults to support tobacco control efforts

b. **Relevant**

Asset 1.3 Amount of local Prop 10 funds that are appropriated for cessation and SHS education targeting pregnant women and families with young children

Asset 2.1 Number of tobacco control advocacy trainings that are provided to youth and adults

Asset 3.4 Extent that educational and media materials used by the agency reflect the culture, ethnicity, sexual orientation, and languages of the communities served, relative to the demographics of the community